(B) MEDICAL PROGRAMS

- Employees in the IBEW Union (hired prior to 8/1/06)
- Non-Medicare-Eligible IBEW Employees (retired between 8/1/00 and 7/31/06)

 IBEW Non-Medicare-Eligible Participants on LTD (terminated between 8/1/00 and 7/31/06)

 CIGNA CAP (PPO)

	CIGNA OAP (PPO)			Vytra PPO		
	In-Network	Out-of-Network	Aetna (HMO)	In-Network	Out-of-Network	HIP (HMO)
Medical Care Provider	Participating physician/facility	Any physician/facility	Participating physician/facility	Participating physician/facility	Any physician/ facility	Participating physician/facility
Payment of Benefits	No claim forms	Submit claim forms	No claim forms	No claim forms	Submit claim forms	No claim forms
Age Limit for Dependent	To age 19/End of	To age 19/End of the	End of the month age 19/End of	To age 19/End of	To age 19/End of the	End of the month age 19/End
Children/Full-Time Student	the year age 23	year age 23	the year age 23	the year age 23	year age 23	of the year age 23
Annual Deductible	N/A	\$250/\$650	N/A	N/A	\$250/\$650	N/A
(Individual/Family)						
Annual Out-of-Pocket Maximum	N/A	\$1200/\$2400	\$1500/\$3000	N/A	\$1200/\$2400	N/A
(Indiv/Family) (Excl. Deductible)						
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Pre-Existing Condition	N/A	N/A	N/A	N/A	N/A	N/A
Limitation						
Office Visits	Covered in full	80% of R&C after	Covered in full after \$5 co-pay	Covered in full	80% of R&C after	Covered in full
	after \$10 co-pay	deductible		after \$10 co-pay	deductible	
Emergency Room	Covered in full	Emergency: Covered in	Covered in full after \$35 co-pay	Covered in full	Emergency: Covered	Covered in full after \$50 co-pay
(Accident/Illness)		full Non-emergency:80%	(waived if admitted)		in full Non-emergency:	(waived if admitted)
(of R&C after deductible	(1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		80% of R&C after	(
					deductible	
Inpatient Hospital						
(Semi-Private Room, Board,	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Services, Supplies)						
	Pre-admission certification required or \$250			Pre-admission certification required or \$250 penalty plus 50% reduction in benefits on any		
	penalty plus 50% reduction in benefits on any					
	days not approved.	s not approved. days not approved.				
(Physician/Surgeon)	Covered in full	80% of R&C after	Covered in full	Covered in full	80% of R&C after	Covered in full
(,::::::::::::::::::::::::::::::::::::		deductible			deductible	
Second Surgical Opinion						
(Office Visit)	Covered in full	100% of R&C	Covered in full after \$5 co-pay	Covered in full	100% of R&C	Covered in full
Laboratory/X-Ray	Covered in full	80% of R&C after	Covered in full after \$5 co-pay	Covered in full	80% of R&C after	Covered in full
	0010104 14	deductible	Covered III rail and the de pay	0010104 1111411	deductible	0010104 14
Maternity (Initial Visit To	Covered in full	80% of R&C after	Covered in full after \$5 co-pay	Covered in full	80% of R&C after	Covered in full
Determine Pregnancy)	after \$10 co-pay	deductible		after \$10 co-pay	deductible	
3						
(Subsequent Visits/Delivery)	Covered in full	80% of R&C after	Covered in full	Covered in full	80% of R&C after	Covered in full
		deductible			deductible	
Prescription Medication (Retail)	\$5 generic/\$10 brand	80% of R&C after	\$5 generic/\$10 brand formulary/	\$5 generic/	80% of R&C after	\$5 generic/\$10 brand
	(up to 30-day supply)	deductible	\$25 brand non-formulary	\$10 brand	deductible	(up to 30-day supply)
			(up to 30-day supply)	(up to 30-day supp	y)	
(Mail Order)	\$10 generic/\$20 brand	Use in-network benefit	\$10 generic/\$20 brand	\$10 generic/	In-network only	\$7.50 generic/\$15 brand
(Mail Oldel)	(up to 90-day supply)	OSC III-HELWOIK DEHEIR	formulary/\$50 brand non-	\$20 brand	III HOLWOIK OHIY	(up to 90-day supply)
	(ap to ourday supply)		formulary (31 to 90-day supply)	(up to 90-day supp	v)	(up to 50-day supply)
P&C - Passanabla & Customary	I		ionnalary (or to ourady supply)	(ap to ou day supp	<i>y</i>	l

R&C = Reasonable & Customary

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 IBEW Non-Medicare-Eligible Participants on LTD (terminated between 8/1/00 and 7/31/06)

	CIGN	A OAP (PPO)		Vytra PPO				
	In-Network	Out-of-Network	Aetna (HMO)	In-Network	Out-of-Network	HIP (HMO)		
Preventive Care								
(Routine Care For Children	Covered in full	80% of R&C after	Covered in full	Covered in full	80% of R&C after	Covered in full (to age 19)		
Including Immunizations)	(to age 19)	deductible (to age 19)	(to age 19)	(to age 19)	deductible			
(Well Woman Exam)	Covered in full	80% of R&C after	Covered in full after \$5 co-pay	Covered in full	80% of R&C after	Covered in full		
	after \$10 co-pay	deductible		after \$10 co-pay	deductible			
(Mammogram)	Covered in full	80% of R&C after	Covered in full after \$5 co-pay	Covered in full	80% of R&C after	Covered in full		
		deductible			deductible			
(Physical Exam)	Covered in full	Not covered	Covered in full after \$5 co-pay	Covered in full	Not covered	Covered in full		
	after \$10 co-pay			after \$10 co-pay				
(Davidina Fra France)	Net en coned	Not servered	Covered in full often OF as now	Carrage dia full	Nat as can d	Covered in full (for ontonestrict		
(Routine Eye Exam)	Not covered	Not covered	Covered in full after \$5 co-pay	Covered in full after \$10 co-pay	Not covered	Covered in full (for optometrist		
				(1 exam/year)		in discount program)		
Mental Health Care (Inpatient)	Same as inpatient	Same as inpatient	Covered in full	Same as inpatient	Same as inpatient	Covered in full		
wentai neattii Care (inpatient)	hospital	•	(Max: 35 days/year)	hospital	hospital	(Max: 30 days/year)		
	поѕрна	hospital	(Max. 33 days/year)	nospitai	поѕрнаі	(iviax. 50 days/year)		
(Outpatient)	Covered in full	80% of R&C after	\$5 co-pay/visit	Covered in full	80% of R&C after	Covered in full		
(Outpationt)	after \$10 co-pay/	deductible	(Max: 20 visits/year for certain	after \$10 co-pay	deductible	(Max: 20 visits/year for certain		
	visit	deddelible	conditions)	and the do pay	deddelible	conditions)		
Substance Abuse Treatment	Same as inpatient	Same as inpatient	Covered in full	Same as inpatient	Same as inpatient	Covered in full		
(Inpatient Detox)	hospital	hospital	Covorca III Idii	hospital	hospital	(Max: 7 days/year)		
(inpation Botox)	noophai	поорна		Поорна	noopha.	(Max. / dayo/your)		
(Outpatient Rehab)	Covered in full	80% of R&C after	\$5 co-pay/visit	Covered in full	80% of R&C after	Covered in full		
()	after \$10 co-pay/	deductible	(Max: 60 visits/year)	after \$10 co-pay/	deductible	(Max: 60 visits/year)		
	visit		, ,	visit		, , ,		
Alternate Care	Covered in full	80% of R&C after	\$5 co-pay/visit	Covered in full	80% of R&C after	Covered in full		
(Home Health Care)		deductible			deductible	(Max: 200 visits/year)		
Non-custodial	(Max: 40 visits/yea	r combined in and out of		(Max: 40 visits/year combined in/out)		,		
	network)			`	ŕ			
(Skilled Nursing Facility)	Same as inpatient	Same as inpatient	Covered in full	Same as inpatient	Same as inpatient	Covered in full		
Non-Custodial	hospital	hospital		hospital	hospital			
1		r combined in and out of	1	(Max: 60 days/year combined in/out)				
	network)							
(Outpatient Short-Term Rehab:	Covered in full	80% of R&C after	\$5 co-pay (Max: 60 consecutive	Covered in full	80% of R&C	Covered in full		
Physical Therapy)	after \$10 co-pay	deductible	days/injury/lifetime)	after \$10 co-pay	after deductible	(Max: 90 visits/year)		
Durable Medical Equipment	Covered in full	80% of R&C after	Not covered	Covered in full	80% of R&C after	Covered in full		
		deductible			deductible			
External Prosthetic Devices	Covered in full	80% of R&C after	Covered in full for initial device	Covered in full	80%of R&C after	Covered in full		
		deductible	only		deductible			
Hearing Aids	Covered in full	80% of R&C after	Not covered	Not covered	Not covered	Not covered		
1		deductible						
Dio Deservable in October	(Max: \$2000/10	(Max: \$2000/1095 days)						

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